



**Texas Department of Insurance, Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor's Name and Address:  TROPHY CLUB MEDICAL CENTER 2850 EAST STATE HIGHWAY 114 TROPHY CLUB TX 76262	MFDR Tracking #: M4-10-2486-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #:  NETHERLANDS INSURANCE COMPANY Rep Box #: 19	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Not paid at 108% APC plus implants. Carrier denied appeal. Implants not paid at cost plus 10% or \$2000 max mark-up."

Principal Documentation:

1. DWC 60 package
2. Hospital Bill
3. EOBs
4. Implant Invoices
5. Implant Billing Certification
6. Total Amount Sought \$42,597.74

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "This dispute concerns DOS 7/27/2009-7/30/2009. The amount in dispute is reported to be \$42,597.74. The Carrier has issued reimbursement in the amount of \$36,985.67. This is the correct amount owed based upon the documentation provided at the time of billing. The Carrier declined reimbursement of several of the alleged implantables because these items were either not actually implantables [Floreal (\$179.95), K-wire (\$456)], were not pre-authorized when they should have been (Bone Growth Stimulator - \$5555.) or the documentation submitted was insufficient to establish the provider's actual cost for the implantable (Cages-\$25,000 invoice not from manufacturer). The Provider is not entitled to the reimbursement sought for those 'implantables.' The provider has been correctly reimbursed for the services provided. No additional reimbursement is owed at this time."

Principal Documentation:

1. DWC 60 package
2. Pre-authorization Letter

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
07/27/2009 through 07/30/2009	Inpatient Hospital Services	\$28,253.81 (DRG 455) (IPPS) X 108% = \$30,514.11 + \$19,321.31 (Implantable Allowance) = \$49,835.43 (MAR) less \$36,985.57 (Total paid by Respondent) = \$12,849.56 (Amount Due Requestor)	\$42,597.74	\$12,849.85
			<b>Total Due:</b>	\$12,849.85

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 TAC §134.404, titled *Hospital Facility Fee Guideline – Inpatient*, effective for medical services provided in an inpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital inpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and meets the requirements for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the respondent with the following reason codes:

Explanation of benefits with the listed date of audit 10/22/2009

- W1 — Workers Compensation State Fee Schedule adjustment. Re-priced in accordance with the DRG rate.
- 16 — Claim/service lacks information which is needed for adjudication. Requests for reimbursement for surgical implants require a statement of certification as defined in per rules 134.402, 403 & 404.
- W1 — Workers Compensation State Fee Schedule adjustment. Re-pricing included in the DRG rate.
- W1 — Workers Compensation State Fee Schedule adjustment. Fee Guideline MAR reduction.

Explanation of benefits with the listed date of audit 11/11/2009

- 18 — Duplicate claim/service. Duplicate charges.
- 150 — Payment adjusted as information submitted does not support this level of service. Documentation does not justify level of service.
- W3 — Additional payment made on appeal/reconsideration.
- 198 — Payment denied/reduced for exceeded precertification/authorization.
- 50 — Requested documentation not submitted with the medical bill. Not documented. In order to review this charge we need a copy of the invoice detailing cost to provider.
- \*\*\* — Paid \$15878.30—Canc. Bone \$345X6 = 1035 + Infuse = \$5408 + Nuvasive Instrumentation paid total billed for instrumentation c ((\$6,880), D (1,534), A (\$952) and 69.30 = \$9435.30. Cages = \$25,000 (did not pay this since invoice is TC Surgical need invoice from manufacturer). Did not pay Floseal - \$179.95 (not implant), K-wire \$456 not implant), BGS - \$5555.00 (Not preauth).

Explanation of benefits with the listed date of audit 12/07/2009

- 193 — Original payment decision is being maintained. This claim was processed properly the first time.

2. The respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
3. The respondent denied reimbursement for supplies/implants based upon documentation does not support level of service billed. The disputed services were implants as defined by Division rule at 28 TAC §134.404 (b)(2)(A-E), therefore, this payment denial reason has not been supported.
4. The respondent denied reimbursement for the bone growth stimulator based upon preauthorization required but not obtained. The requestor did not provide documentation to support their position that the disputed service was preauthorized in accordance with 28 TAC §134.600. Review of the respondent's preauthorization approval letter dated 06/29/09 under preauthorization number 928978 shows preauthorization was approval given for CPT codes 22842, 63090, 63047, 63048, 22558, 22851, 22612 and 22614. The disputed bone growth stimulator was not included as a requested/approved service. Therefore, this payment denial reason has been supported.
5. Texas Labor Code §413.014(b) states "the insurance carrier is not liable for those specified treatments and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 TAC §134.600(c)(1)(B) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care...only when the following situations occur...preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care."
6. Division rule at 28 TAC §134.404(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
- (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
7. Pursuant to Division rule at 28 TAC §134.404(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
- (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

8. Pursuant to Rule §134.404(g), “Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1))B) of this section, shall be reimbursed at the lesser of the manufacturers invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, which ever is less, but not to exceed \$2,000 in add-on’s per admission.
  - (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: ‘I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge’.”
9. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
  - (1) No documentation was found to support a contractual agreement between the parties to this dispute;
  - (2) MAR can be established for these services; and
  - (3) The submitted documentation supports that the provider requested separate reimbursement for implantables with the billing in accordance with Division rule at 28 TAC §134.404(f)(1)(B).
10. Review of the submitted documentation finds documentation to sufficiently support that the carrier received the billing certification as required for billing separately for implantables as prescribed under Division rule at 28 TAC §134.404 (g).
11. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.404(f)(1)(B) as follows:

Total Implantables Billed	Net Invoice Amount Per Implantable	Implant Description	Lesser of 10% or \$1,000 per Billed Item Add-On §134.404(g)	Total Net Implantable Amount + Total Add-On (not to exceed \$2,000 total add-on’s per admission)
\$1,720.00 x 4 = \$6,880.00	\$1,660.00 x 4 = \$6,640.00	Cannulated Polyaxial Screw	\$664.00	\$7,304.00
\$238.00 x 4 = \$952.00	\$114.00 x 4 = \$456.00	DBR Screw Lock Screw	\$45.60	\$501.60
\$179.90	\$179.83	Floseal Hemo Sealant	\$17.98	\$197.81
\$767.00 x 2 = \$1,534.00	\$1,695.00 x 2 = \$3,390.00	Pre-bent Rod	\$339.00	\$3,729.00
\$5,408.00	\$5,408.00	Inf Bone Graft Kit	\$540.80	\$5,948.80
\$345.00 x 3 = \$1,035.00	\$345.00 x 3 = \$1,035.00	Cancellous, Crushed	\$103.50	\$1,138.50
\$5,555.00	\$5,555.00	Bone Growth Stimulator - Preauthorization Required/Not Obtained in accordance with Rule 134.600	\$0.00	\$0.00
\$114.00 x 4 = \$456.00	\$114.00 x 4 = \$456.00	Blunt Tip Wire	\$45.60	\$501.60
\$34.65 x 2 = \$69.30	Undetermined - No Invoice Provided	Undetermined - No Invoice Provided	\$0.00	\$0.00
\$5,000.00 x 5 = \$25,000.00	No Invoice from Manufacturer Provided	Undetermined – No Implant Description or Invoice from Manufacturer Provided	\$0.00	\$0.00
<b>\$47,069.20</b>	<b>\$23,119.83</b>		<b>\$1,756.48</b>	<b>\$19,321.31</b>

The Medicare Facility Specific Reimbursement Amount including Outlier Payment Amount for DRG 455 is \$28,253.81.

\$28,253.81 multiplied by 108% = \$30,514.11.

The net invoice amount for implantables is \$17,564.83 + \$1,756.48 total add-on = \$19,321.31.

\$30,514.11 + \$19,321.31 = \$49,835.42 (MAR) less \$36,985.57 previously paid by carrier = \$12,849.85 due to requestor.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is \$12,849.85.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code §413.011(a-d), §413.031, §413.0311  
28 TAC Rule §134.404, §133.305, §133.307, §134.600

**PART VII: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **\$12,849.85** plus applicable accrued interest per Division Rule §134.130, due within 30 days of receipt of this Order.

December 13, 2010

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Auditor

\_\_\_\_\_  
Date

December 13, 2010

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Director, Health Care Business Management

\_\_\_\_\_  
Date

**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**